Rehabilitation and Sports Medicine Center Locations

1 Central
601 West Second Street, Bloomington, IN 47402
t 812.353.9484 | 800.934.6074

2 East
328 S. Woodcrest Drive, Bloomington, IN 47401
t 812.353.3278 | 866.353.3278

3 West
2499 W. Kota Drive, Bloomington, IN 47403
t 812.353.9378 | 866.353.9378

4 Monroe County YMCA
2125 S. Highland Avenue, Bloomington, IN 47401
t 812.961.2158

5 Spencer
5 Crane Avenue, Spencer, IN 47460
t 812.829.3296 | 800.939.0491
WELCOME TO IU HEALTH BLOOMINGTON REHABILITATION AND SPORTS MEDICINE CENTER

Our goal is to provide you with high quality care and customer service. We hope you will be happy with the services you receive and that our staff is quick to respond to your needs. If you have questions regarding your paperwork and/or appointments, please call the location where your initial evaluation appointment is scheduled:

Central       East       Spencer       West      YMCA-Monroe Co.

After completing your therapy, you may receive a customer survey in the mail. If so, please take time to complete and return the survey. Your feedback will help us improve the quality of care we provide.

During your therapy, if you have any comments, concerns or suggestions for improvement, we would love to hear from you. Feel free to call:

IU Health Bloomington
Rehabilitation and Sports Medicine Center
Exceeding Expectations Customer Service Hotline
812-353-5388 or toll free 877-353-5388

If you would like us to return your call, leave your name and telephone number.

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HOW TO GET THE MOST FROM YOUR THERAPY

1. You need to be actively involved to get the best results from your therapy. Please follow the therapist’s instructions and make it a priority to keep all of your appointments.

2. Arrive on time for each appointment. If you are running late, please call so we can decide if you need to reschedule.

3. Today the therapist will:
   - evaluate your function, pain, and mobility
   - create and send a treatment plan to your physician for approval

4. Your physician must approve all the care your therapist provides. Your therapist and physician will work together using a written care plan and progress notes.

Patient-Last Name, First Name, Middle Initial   ☐ M ☐ F   Age

Admission Number   Date   Birth Date

Physician Name

184938  11/6/13   PATIENT INFORMATION
PATIENT INFORMATION

APPOINTMENTS AND SCHEDULING

1. Call as soon as possible if you need to cancel an appointment. Cancellations may result in discharge from therapy.

2. When you do not call to cancel or don’t come to your appointment we consider this a “no show”. No shows may result in discharge from therapy.

3. We will need a new therapy order from your physician if:
   - one month has passed between your appointments
   - you have had surgery OR
   - you have been admitted to the hospital

4. If you bring children with you, someone else must watch them at all times. They are not allowed to play on therapy equipment.

BILLING

1. You must call your insurance company to make sure your therapy is covered.
   - Payments to IU Health Bloomington are based on your insurance policy.
   - Pre-certification may not guarantee payment by your insurance company.

2. On the first day of the month, the hospital will send your insurance company your charges from the prior month.

3. You will get an explanation of payment or non-payment from your insurance company. You will then receive a bill in the mail for any charges not covered by insurance. Please call our Patient Accounts Department at 812-353-9143 or 800-223-2997 if you would like an itemized bill, or to check your current balance. They can also answer billing questions, set your account up on a payment plan, or help with financial assistance if needed.

4. As a courtesy, you will be given a Written Disclosure that will provide you with your plan of care and basic financial information. This information is not a guarantee of coverage or costs.

By signing below, I acknowledge that I have read and understand the above information. I also acknowledge that I have received a copy of this form.

Patient/Parent/Guardian/Representative (printed)  Patient/Parent/Guardian/Representative (signature)

________________________________________
Relationship to Patient

□ M □ F  Age

________________________________________
Patient-Last Name, First Name, Middle Initial

________________________________________
Admission Number    Date    Birth Date

________________________________________
Physician Name

________________________________________
Patient Identification    Medical Record Number

184938  11/6/13  PATIENT INFORMATION
Date ______________
Date of Onset ______________
Date of Surgery ______________
Brief description of issue ______________________________________
________________________________________________________________________________

Have you received previous care for this issue? If yes, briefly describe ____________________________
________________________________________________________________________________

Check any medical conditions or medical diagnoses that apply to you.

☐ Arthritis / joint problems  ☐ Night sweats
☐ Asthma  ☐ Nutritional concerns
☐ Balance Issues  ☐ Osteoporosis
☐ Bleeding disorders  ☐ Pacemaker/Defibrillator
☐ Cancer  ☐ Polio
☐ Diabetes  ☐ Pregnant (currently)
☐ Dizziness  ☐ Recent fatigue / weakness
☐ Fainting/blackouts  ☐ Recent Illness (cold, flu)
☐ Fibromyalgia  ☐ Respiratory problems
☐ Fractures  ☐ Seizure / Epilepsy
☐ Head Injury  ☐ Sores not healing
☐ Heart Condition  ☐ Stomach Ulcers
☐ High Blood Pressure  ☐ Stroke
☐ History of falling  ☐ Thyroid
☐ Low Blood Pressure  ☐ Unexplained weight loss / gain
☐ Migraine Headaches  ☐ Smoking ( ___ packs per day)
☐ Anxiety / panic attacks
☐ Depressed or withdrawn
☐ Self-mutilation
☐ Hopelessness
☐ Major loss or life changes
☐ Failing at work or school
☐ Change in behavior, attitude, appearance

☐ Writing or talking about death or suicide
☐ History of suicide in family, suicide attempts
☐ Feelings of deep loneliness, sadness or guilt
☐ Lack of self-worth
☐ Reckless behavior
☐ Loss of appetite or weight loss
☐ Substance abuse (alcohol, recreational drugs)
Check any previous surgeries

☐ Head  ☐ Neck  ☐ Shoulder  ☐ Back
☐ Heart  ☐ Abdominal  ☐ Elbow  ☐ Wrist
☐ Hand  ☐ Hip  ☐ Knee  ☐ Ankle
☐ Foot

List the medications you are taking (include over-the-counter, herbal supplements, and medication used as needed).

☐ See attached list  ☐ Not applicable

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<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
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Do you have allergies to:

☐ Latex  ☐ Food  ☐ Adhesives  ☐ Cortisone
☐ Environmental

Do you have any adverse or allergic drug reactions:

☐ No  ☐ Yes

If yes, please list

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<th>Drug</th>
<th>Reaction to Drug</th>
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Patient-Last Name, First Name, Middle Initial

☐ M  ☐ F

Age

Admission Number

Date

Birth Date

Physician Name

Patient Identification

Medical Record Number

184963  11/6/13

PATIENT INTAKE
Before this issue, did you have limitations to any activities? ______________________________________
________________________________________________________________________________

What does this issue limit you from doing now? ______________________________________________
________________________________________________________________________________

Therapy Goal: By the end of therapy, I would like to be able to __________________________________
________________________________________________________________________________

What is your current level of pain?  
(0=No pain, 10=Worst possible pain)  
0 1 2 3 4 5 6 7 8 9 10

What is an acceptable level of pain?  
(0=No pain, 10=Worst possible pain)  
0 1 2 3 4 5 6 7 8 9 10

Does your pain interfere with:  
[ ] Sleep  [ ] Appetite  [ ] Physical Activity  [ ] _____________

What decreases your pain? ________________________________
________________________________________________________________________________

What increases your pain? ________________________________
________________________________________________________________________________

How would you rate your current quality of life and health?  
[ ] Excellent  [ ] Good  [ ] Fair  [ ] Poor

Do you live alone?  [ ] Yes  [ ] No  
If No, who with? ______________________________________

Do you have assistance if needed? ___________________________________________________________________

Do you own any equipment to help with your condition?  
[ ] Crutches  [ ] Cane  [ ] Walker  [ ] Rolling walker  [ ] Rollator  [ ] Bedside Commode  
[ ] Grab bars  [ ] Wheel chair

Are you married?  [ ] Yes  [ ] No

Do you have children?  [ ] Yes  [ ] No  
How many? __________

Do they live with you?  [ ] Yes  [ ] No

Are you currently employed?  [ ] Yes  [ ] No

Occupation ______________________________________

Recreational Activities/Hobbies ______________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Patient-Last Name, First Name, Middle Initial  [ ] M  [ ] F  __________

Admission Number  Date  Birth Date

Physician Name

Patient Identification  Medical Record Number

184963  11/6/13  PATIENT INTAKE
Do you have any particular religious or cultural beliefs / practices we need to consider in your care?  
☐ No ☐ Yes

Is there anything that would limit your ability to learn?  
If yes, please explain______________________________________________

☐ No ☐ Yes

Please check your preferred learning style. ☐ Written ☐ Verbal ☐ Demonstration

What is your highest level of education?  
☐ High School ☐ Vocational ☐ College ☐ _______

Are you concerned about your level of anxiety and / or coping ability?  
☐ No ☐ Yes

Do you feel you need any information about community resources or services?  
☐ No ☐ Yes

Is there anything that would limit your ability to return for follow-up visits?  
☐ No ☐ Yes

Is anyone at home, work or school harming you?  
☐ No ☐ Yes

Do you have any concerns about your home environment?  
☐ No ☐ Yes

Have you had any recent exposure to lice, scabies, or bed bugs?  
☐ No ☐ Yes

May we leave a detailed message on your voice mail / answering machine pertaining to your follow-up appointments?  
☐ No ☐ Yes

Do you have an Advanced Directive?   
☐ Yes, copy on file with IU Health  
☐ Yes, I will bring a copy at next appointment  
☐ No, I would like information  
☐ No, I am not interested in information at this time

The above information reflects my current health status and past medical history.

__________________________________________ Date

Patient / Parent / Legal Guardian’s Signature

☐ M ☐ F    __________

Patient-Last Name, First Name, Middle Initial Age

Clinician Signature Date

Patient Identification Medical Record Number

184963 11/6/13 PATIENT INTAKE